



Flexible Spending Enrollment Form

Employer name: City of Stockton			Plan Year: 2016-2017	
Last Name	First Name	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	
			Social Security #	
Street Address		City	State	Zip Code
Home Phone Number ()	Date of Birth	Date of Hire	<input type="checkbox"/> Single <input type="checkbox"/> Family	
Email Address:				
Payroll Cycle: <input type="checkbox"/> Semi-Monthly Date of first payroll deduction: Month _____ Day _____ Year _____				
Spouse Name		Date of Birth		
Dependent Name		Date of Birth		
Dependent Name		Date of Birth		
Dependent Name		Date of Birth		

Account Type	Election Amount	Monthly Administration Fee
Health Flexible Spending Account: Maximum \$2,550 Annually (example: doctor co-payments, eye glasses)	_____ Annual	Health Flexible Spending Account Only = \$3.40/month Dependent Care Flexible Spending Account Only = 3.40/month Transportation Account Only = \$3.25/month
Dependent Care Assistance Account: Maximum \$5,000 Annually (example: daycare, assisted living facilities)	_____ Annual	Health AND Dependent Care Account = \$3.40/month Health +/-or Dependent Care AND Transportation = \$6.65/month

Minimum reimbursement amount for manual check is \$25

Please note: For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the first of the month following date of receipt. Claims reimbursement will be made only for expenses incurred on or after the signature date.

AUTHORIZATION

I hereby elect the benefits indicated above. I have read and understand the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the Summary Plan Description (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT _____ **DATE** _____

**Please return all enrollment forms to the Human Resources Department
22 E. Weber Avenue Suite 150, Stockton, CA 95202
Phone: (209) 937-8233 Fax: (209) 937-5702**